Center Child Care Central Database Application

CENTER INFORMATION _____ **RENEWAL**

Check if new address, phone number or contact person _____

Center Name _____ Tax ID Number _____

Street Address _____

City _____ State ___VA___ Zip Code _____

Phone # _____ Alternate Phone # _____ Fax #_____

E-mail Address_____Website Address:_____

Director _____Contact Person _____

REGULATION ***Which category applies to your program?***

___ State License (Dates) from _____to_____ ___ Religious Exemption ___ Certified Preschool

ACCREDITATION

Is your program accredited by the National Association for the Education of Young Children? ___Yes ____ No

Other accreditation(s) _____

AFFILIATION ***Is your program affiliated with any outside organizations?*** ____Yes ____No

If yes, please list all that apply.

___College ___Community-based ___Employer-sponsored ___Faith-Based ___For Profit ___Independent

___Local Chain ___National Chain ___Non-Profit ___Private School ___Public Agency ___Public School

Does your program participate with the USDA Food Program? ___*Yes* ___*No*

ENVIRONMENT

Is your center near public transportation? ___Yes ___No ***Is your center wheelchair accessible?*** ___Yes ___No

PROGRAM ENHANCEMENTS: ***List the types of programs your center provides.*** (Check all that apply)

___Parent Co-op ___Early Intervention ___Head Start ___Infant/Toddler only ___Kindergarten/Pre-K
___Mixed Age ___Parents Day Out ___Preschool ___Private School ___School Age only
___School-based ___Summer ___Other (please specify)_____

REGISTRATION FEE **$ _____** ___ One-time ___ Yearly

FEES

Check all ages you serve: ***Monthly Rates:***

___ Infants (birth - 15 months) $_____
___ Toddler (16 - 23 months) $_____
___ Two-year old (24 – 35 months) $_____
___ Young Preschool (36 – 47 months) $_____
___ Older Preschool (48 – 59 months) $_____

___ Kindergarten (60 – 71 months) $_____ full day
___ before and after kindergarten $_____
___ School age (72 months – 13 years) $_____ full day
___ before and after school $_____

Care Level

SCHEDULE Hours and days of operation as well as alternative schedules you offer

Hours of Operation: Open _____ a.m. Close _____ p.m.

Minimum age you would enroll _____ mos/yrs Maximum age you would enroll _____ mos/yrs

Schedule Options: ___ Full-time ___ Part-time

Days of Operation: ___ Sun ___ Mon ___ Tues ___ Wed ___ Thurs ___ Fri ___ Sat

Alternative Options you are willing to consider:

___ before school
___ after school
___ before/after preschool
___ holidays/vacation
___ school year only
___ year round
___ extended hours
___ occasional/back-up
___ shift/rotating week
___ morning
___ evening care
___ weekend care
___ summer only
___ before/after camp
___ 24-hour

SPECIAL SERVICES

Experience or training in the care of children with special needs____ Yes ____ No

Check if you have staff with experience or training to provide the following types of special care:

__ Adaptive/special equipment (apnea monitor, catheter, g-tube, nebulizer)
__ Allergies
__ Asthma/respiratory conditions
__ Cerebral Palsy, neurological or seizure disorder
__ Development delay (language/speech delay)
__ Diabetes
__ Dispense Medication
__ Down's Syndrome
__ Emotional/learning disabilities (ADHD/ADD, autism, challenging, behaviors)
__ Physical Impairments (hearing impaired, motor impairment, visually impaired)
__ Physical or occupational therapy
__ Special diets
__ Other (please specify) _____

Language: ***Please list the languages spoken by your staff:*** ___ English ___ Spanish ___ Vietnamese ___ Farsi ___ Korean ___ Hindi ___Punjabi ___ Other (please specify) _____

Can anyone in your program use sign language? ___ Yes ____ No

TRANSPORTATION Transportation services provided as part of your program

Do you transport children: To/From their home to your care? __ Yes __ No

List the elementary school(s) you are near and whether transportation is available to and/or from the school(s) and your program. The transportation can be either by school bus or your program vehicle.

School Name_____ ___ to school ___ from school
School Name_____ ___ to school ___ from school
School Name_____ ___ to school ___ from school

Signature _____ **Date** _____

By signing this application to become part of the Child Care Central Database, I understand that information about my program will be made available to the public through the Office for Children's Child Care Central Website and on listings requested by parents. I also understand that the Office for Children reserves the right to remove a child care program from the Child Care Central Database.

Please call Community Education and Provider Services at (703) 324-8100 with any questions. www.fairfaxcounty.gov/childcare

FAIRFAX COUNTY OFFICE FOR CHILDREN
12011 Government Center Parkway 8th floor, Suite 820
Fairfax, VA 22035-1104
Fax: (703) 324-3925

For Office Use Only

CCMS # _____ Map Code _____

Application Received _____ Date entered into CCMS _____